

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-039206

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 53

Primary Registration District No. 3010

Registrar's No. 482

VS 300
Rev. 4/59

1 0168

2 1001

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12 3-0

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

FILED OCT 25 1963

1. PLACE OF DEATH a. COUNTY CAPE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY SCOTT	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CAPE GIRARDEAU		c. CITY OR TOWN CHAFFEE	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. FRANCIS HOSPITAL		d. STREET ADDRESS (If outside, give location) 528 W. YORKUM AVE	
3. NAME OF DECEASED (Type or print) First Middle Last STELLA MAE SHORES		4. DATE OF DEATH Month Day Year OCT. 17, 1963	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH JULY 3 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (City and state or country) STODDARD COUNTY, MO.	
13a. FATHER'S NAME WILLIAM GOODMAN		13b. MOTHER'S MAIDEN NAME GLORA BELL THOMAS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		17. INFORMANT RAY SHORES - CHAFFEE, Missouri	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. Coronary Artery Sclerosis Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 11 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION CAPE GIRARDEAU	
21. I attended the deceased from Sept 15, 1963 to Oct 17, 1963 and last saw him alive on Oct 15, 1963		22. DATE SIGNED Oct 21, 1963	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE OCT. 20, 1963	
23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK CEMETERY		23d. LOCATION (City, town, or county) (State) CAPE COUNTY, Missouri	
24. FUNERAL DIRECTOR DISPLINGHOFF FUNERAL HOME - CHAFFEE, Mo.		25. DATE RECD. BY LOCAL REG. 10-21-63	
26. REGISTRAR'S SIGNATURE John Kasten			

USE BLACK INK

OR

TYPEWRITER RIBBON

OCT 28 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Jack T. Burnett

Licensed Embalmer No.

4473

P. O. Address

Chaffee, Missouri

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.